

FILED DEC 2 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 39328

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>4076</u>		Registrar's No. <u>2852</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis County</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis &amp; NORMANDY</u>				c. LENGTH OF STAY (in this place) <u>48 yrs. 5 mo.</u>			
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis County RURAL NORMANDY TWN.</u>				d. STREET ADDRESS (If rural, give location) <u>4280 7300 St. Chas. Rk. Rd., St. Louis, 14</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. VINCENT'S SANITARIUM</u>							
3. NAME OF DECEASED (Type or Print)		a. (First)		b. (Middle)		c. (Last)	
		<u>VARNEY, Elizabeth</u>		<u>VARNEY</u>		<u>VARNEY</u>	
4. DATE OF DEATH		(Month)		(Day)		(Year)	
		<u>11</u>		<u>25</u>		<u>1950</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>		8. DATE OF BIRTH <u>1882</u>	
9. AGE (in years last birthday) <u>65 or 67</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>James Varney</u>		13b. MOTHER'S MAIDEN NAME <u>Mary (?)</u>		14. NAME OF HUSBAND OR WIFE <u>Pt. never married.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT'S SIGNATURE OR NAME <u>(Hospital Records)</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Transverse Colon</u>  ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u> <u>Metastasis to the Liver</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Approx 1-11-2-50</u>  <u>1537</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>1537</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>--</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>--</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Under care of hosp. staff</u>			
22. I hereby certify that I attended the deceased from <u>8-9-02 (6-9-02)</u> to <u>11-25-50</u> , 19____, that I last saw the deceased alive on <u>11-25-50</u> , 19____, and that death occurred at <u>12:28p m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>W.B. Lytton m.d.</u>				23b. ADDRESS <u>ST. VINCENT'S SANITARIUM</u>		23c. DATE SIGNED <u>11-25-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov. 28, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>	
DATE REC'D BY LOCAL REG. <u>11/27/50</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Donker M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Cullen &amp; Kelly</u>		ADDRESS <u>7267 Natural Bridge</u>	

Signed Embalmer's Statement on Reverse Side

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed \_\_\_\_\_

*James A. Lammers*

Signed .....  
Student Embalmer

Licensed Embalmer No. 4142

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.